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Moving upstream in health promoting policies for older people with early frailty in England? A policy analysis

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Declaration of conflicting interests

None Declared

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Abstract

Objectives

Internationally, populations are rapidly ageing. Governments have created health promotion and wellbeing strategies to address increasing demand for health care and old-age support. The older population is not homogeneous, and includes a large group in transition between being active and healthy to being frail, i.e. with early frailty. This review explores the extent to which public policy has addressed this group with a view to supporting independence and preventing further progression towards frailty.

Methods

A narrative review was conducted of 157 health and social care policy documents current in 2014-2017 at three levels of the health and social care system in England.

Findings

We report the policy problem analysis, the shifts over time in language from health promotion to illness prevention, the shift in target populations to mid-life and those most at risk of adverse outcomes through frailty, and changes to delivery mechanisms to incentivise attention to the frailest rather than those with early frailty. We found that older people in general were not identified as a specific population in many of these policies. While this may reflect a welcome lack of age discrimination it could equally represent omission through ageism. Only at local level did we identify some limited attention to preventative actions with those people with early frailty.

Conclusion

The lack of policy attention to older people with early frailty is a missed opportunity to address some of the demands on health and social care services. Those with early frailty are estimated to be nearly half of those aged over 65 years, a population which is growing in all countries. Addressing the individual and societal consequences of adverse experiences of those with the greatest frailty should not distract from a more distinct public health

perspective which argues for a refocusing upstream to health promotion and illness prevention for those with early frailty.

Background

Internationally, most populations are ageing rapidly, accompanied by an epidemiological shift to a predominance of non-communicable diseases, especially chronic ones [1]. This transformation requires public policy makers to address increasing demand for healthcare and old-age support in the context of a declining labour force [2]. Principles and key actions for national policy makers were agreed in the Madrid International Plan of Action on Ageing. This addressed three priority areas: older people and development; advancing health and well-being into old age; and ensuring enabling and supportive environments [3]. Implementation strategies [3] have been agreed with national commitments, as illustrated here from Europe, "*to strive to ensure quality of life at all ages and maintain independent living including health and well-being*" (p.13) underpinned by policies supporting health promotion and disease prevention [4] . However, older people are not a homogenous population. The concept of frailty is of value to healthcare providers and policy makers in differentiating those at most risk of adverse outcomes and utilising most health and social care resources[5]. Frailty "*is a state of vulnerability to poor resolution of homeostasis following a stress and is a consequence of cumulative decline in multiple physiological systems over a lifespan"* and is common among those aged over 75[5]. A spiral of worsening frailty has been identified with increasing disability, risk of unplanned hospital admission and moving into care homes [5]. Reducing distressing and costly unplanned hospital admissions for older people is a policy objective in many healthcare systems although the evidence base on the preventative actions that could best achieve this goal are unclear. One strategy could be to re-focus attention 'upstream'[6] to health promoting and preventative actions with older people who are in transition from being robust towards frailty, i.e. with early frailty, reported to be 44% of older people in high and middle income countries[7] . The extent and mechanisms within health policy that this re-focusing involves have not been explored. This paper reports on a policy analysis [8] that investigated the extent to which health and social care policy in England addresses health promotion with older people with early frailty. We use the term early frailty in this paper rather than pre-frailty as it draws on a cumulative deficits model of frailty rather than a clinical phenotype model[5].

Policy review and analysis help explain past successes and failures identify gaps as well as plan for the future reforms. Context is everything in policy analysis [8]; consequently this

review focused on one country. It was framed by theories of public policy as processes including problem analysis, formulation and implementation in which different interests, interest groups, institutions and ideas interact[9]. These theories include recognition of the exercise of power (overt, indirect and latent) by different interest groups; within this context this included the influence of ageism[3].

In England the evidence of changing demography, epidemiology and potential impact on the economy and public spending costs has been known to governments for decades and was recently re-quantified [10]. There has been ministerial commitment to the Madrid Plan of Action [3] and subsequent re-affirmations. This has translated into a range of policies that specify the promotion of health and well-being for older people and maintaining independence features as strategic objectives, including those for longer working lives[11], for housing[12] and for transport [13] . This paper now reports on the policy analysis which investigated how health promotion for older people with early frailty has been constructed within English health and social care policy documents, which policies have been developed, and how they have been implemented at different levels of the state.

Method

A narrative review was undertaken using a method of documentary analysis [14]. It included policy created at three levels in the state [9] : firstly, that of state laws, secondly, that of the strategies and plans of government-mandated national bodies for health and social care, and thirdly, that of government-mandated bodies at local administrative levels for health and social care. The policies had to be current between 2014- 2017 (i.e. current legislation, published strategies and plans in the period, or referred to as current on government websites or documents of the period) and address one of the following:

- A population of older people (without an age specific definition),
- Public health and wellbeing for whole populations including older people,
- Publicly funded health and social care services for whole populations including older people.

Internet searches of government websites were conducted periodically between 2014 - 2017. An internet search of representative sample (covering all regions and a range of socio-demographic features) of 10 local government and corresponding NHS commissioning

websites was conducted in 2015 and updated in 2017. A snowball technique followed linked policies. Seventy nine national level and 78 local level documents were identified. Each document was reviewed for key words, such as 'older people', 'elderly', 'frail', 'frailty', 'health promotion', 'ageing well'. Relevant surrounding text on the problem analysis, planned actions and stated intent as well as absence of attention to this group was noted. Iterative analysis was discussed within the research team meetings and a final narrative analysis written.

Findings

The policy problem analysis of the ageing population with a changing epidemiological profile and the consequences for society (national and local) was re-stated at the beginning of every policy document as exemplified in the public health white paper [15], The NHS Five Year Forward Plan [16]and local government Health and Well Being Strategies [17]respectively:

> "*Today, people in England are healthier and are living longer than ever before……. We expect more people to have long-standing illnesses in future, and common mental health disorders are on the rise.*" [15 p11]

> "*So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making*"[16 p2]

> "*The ageing population, economic downturn and resultant austerity measures has placed an even greater burden on the health challenges for our city*." [17 p4]

The findings are reported within the following themes: policy formulation-shifts in language and target group, policy solutions and delivery mechanisms, and policy iterations and outcomes.

Policy formulation: shifts in language and target group

At the state level solutions included directions for Local Authorities [18], the NHS [16] and for social care provision[19] to take "preventive actions" for all adults. The change of language over time in these documents is worth noting. The term 'health promotion' while evident in an overarching document (the National Service Framework for Older People [NSFOP] [20]

published first in 2001 and re-endorsed without revision in 2017), is not used in subsequently published and current policy documents. The term 'health promotion' was used only in policies for children and young people [18]. Policies concerned with older adults used more specific language such as '*prevention of ill health*' in pursuit of the policy objective of reducing premature deaths[21]. Prevention of ill-health became a priority strategy for the health and social care system in addressing the ageing population embedded in legislation and government directions to national public services [15,18,19] and in the objectives passed from national bodies to local public services[,22,23].

The Care Act 2014 in England [19] for the first time mandated the social care system to promote well-being and prevent or delay the need for care, recognising different levels of preventative activity [24]. Prior to this these were objectives associated with the 'health' system. This is perhaps illustrative of the wider policy aspiration for greater integration between the health and social care systems, particularly to relation to increasing care provided outside of hospitals for older people (amongst others) with long-term conditions [18,25] .

It is also evident that the target population for prevention has also shifted. In the NFSOP first published in 2001 three groups were identified: the well and healthy, the frail, and then a transition group between the two [21] - essentially those with early frailty. However, there is little explicit consideration of those with early frailty in later policies reviewed here.

Policy solutions and delivery mechanisms

The policy solutions can be inferred to some degree from the national health improvement outcome measures for public health, NHS and adult social care that include older adults [26, 27, 28]. These include the public health objectives across the population of increasing physical activity, decreasing obesity and decreasing smoking. Primary prevention objectives of cancer screening and vaccination coverage targets are age specific, for example, increasing influenza vaccination coverage in the over 65s. Other objectives are summarised in Box 1.

Box 1 Here

The term 'older people with frailty' featured rarely at state policy level. In social care policy it was only used three times as one of a number of examples of types of people who needed

additional social care attention (as a specified group in judicial determination of intimidated witnesses, as an example of the types of people with care home debts, and as people with confusion due to infections[24]). In public health policy it was used only in relation to the population experiencing excess winter deaths[16] and translated into local level action through the annual joint cold weather plans as directed by Public Health England [30]. In health service policy it was only used in relation to improved integration of services for those most vulnerable, particularly for those with long-term conditions[25,31].

We identified the mechanisms for achieving these objectives in state and national agency policies. We identified the following mechanisms within the responsibilities assigned to Local Authorities – some of which were more prescriptive than others:

- Directions for inclusion of preventative actions for older people across all responsibilities and activities, for example for safe neighbourhoods, leisure and housing [24] ,
- The provision of the NHS Health Check programme (through their public health function from 2013) aimed to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia both across the population aged 40-74 years and within high risk and vulnerable groups [31]. This has mostly been commissioned through general practice but in some areas through local pharmacies and community leisure/sports facilities [32,33],
- The creation of Community Agent roles (volunteer support in rural areas) and community groups by the voluntary sector to support adults over the age of 60 becoming socially excluded [15],
- The duty on the local authority "to provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals' needs for care and support, or the needs for support of carers"[24 section 2.23].

Within the responsibilities of the NHS we identified the following mechanisms for achieving the outcomes:

- The provision of primary prevention activities such as discussing and recording smoking status and offering smoking cessation support within the Quality and Outcome Framework for general practices [34],
- The provision of a named and accountable General Practitioner (GP) for all those patients aged over 75 [35], with a responsibility to provide a health check on request if there has not been a medical examination in the previous year,
- The option for general practices to provide the proactive care programme within general practice contract 2014-2015 [36]. This programme aimed to prevent unplanned hospital admissions and support living at home for the most frail and other vulnerable groups.

These seven delivery mechanisms span statutory and voluntary services but utilising general medical practice for four of them. The mechanisms utilise volunteers, trained peers, non-professionally qualified staff as well as professionally qualified staff. They range from broad types of preventative actions without associated identified finance to those for general practice which were more specific and financially incentivised.

The extent to which the preventative actions address those with early frailty is debatable, for example the NHS Health Check primarily targets a younger population [32].and the provision of a health check for those over 75 did not specify what that included or suggest it presented the opportunity for prevention in those with early frailty. The proactive care programme [36] was targeted at the frailest two percent of the older population at risk of unplanned hospital admission. It was a companion to other policies aimed at supporting frail older people to remain independently at home, such as the improved integration of health and social care services [25] and the creation of the Better Care Fund [37]. These policies aimed to build bridging mechanisms in the context of a system where publicly funded health care and social care are divided by different funding mechanisms, governance, commissioners and provider organisations [38]. These exemplars [35,39,40] illustrate the attention given at all levels of the state to integration of planning and services in order to reduce unplanned hospital admissions of frail older people:

> "*The NHS Commissioning Board is uniquely placed to coordinate a major drive for better integration of care across different services…… Local commissioners have the*

vital role of stimulating the development of innovative integrated provision – for example, across primary, secondary and social care, or for frail elderly patients." Department of Health Mandate 2013 39 section 2.7, 2.8, 2.9).

"*The new 2014/15 enhanced service ('Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people') now referred to as the 'proactive care programme'– is designed to bring about a step change in the quality of care for frail older people and other patients with complex needs*." NHS England Transforming Primary Care 2014 [35] page 1.

"*Improving primary care … to do this we will implement the clinical commissioning improvement plan which is designed to support the strategic principle of shifting the delivery of care closer to home, building strong local integration of care, focussing on supporting improvement in the management of frail elderly and complex patients; building on the requirements to support people over 75 contained in the core primary care contracts, as well as the new admission avoidance Directed Enhanced Service*;" Dorset Clinical Commissioning Group 2014 40 page 13.

The extent to which the other mechanisms listed above were visible in local strategies in 2015 varied, with most being described in broad non-specific terms as illustrated in the text exemplars in Box 2 [41, 42]. It should also be noted that a third of the local areas' Joint Health and Wellbeing Strategies of the nine we examined contained no specific priorities for older people.

Box 2 Here

By 2017 our review of the nine joint NHS and Local Authority Sustainability and Transformation Plans (which covered our 2015 local areas) found variability again. All had priorities for preventative activities but only four related these to the older population. Only four mentioned services for frail older people and two of these only in relation to those who were medically unwell.

Policy iterations and outcomes

A key challenge for policy evaluators is to quantify the impact of preventative measures which are often long term in their ambitions [43]. Just as there has often not been a specific focus on older people or those with early frailty in the policies reviewed here, there has been no specific published evaluation of impact for this group. One explanation may be the localism inherent in the major policy reforms of the period that resulted in an absence of evaluation at scale. Another possible explanation is the lack of attention is influenced by the pervasive nature of ageism in society. Oliver et al. [44] argued that it is the latter, citing the absence of older people and those with frailty in the planning and scrutiny work of joint Health and Wellbeing Boards composed of Local Authorities, local NHS commissioners and others).

Those mechanisms without specified public funding, such as Community Agents, are harder to judge in respect of the extent of implementation and outcome. An internet search identified that some rural areas have incorporated these ideas in wider Village Agent schemes, not necessarily focused on older people or those with early frailty.

Those initiatives with public funding have some published evaluations and indications of implementation. The NHS Health Check had higher uptake by those aged 60-74 years than younger groups and variable patient experiences [45] . However it was not designed to address the needs of those with early frailty. The Proactive Care Programme was focused on the most frail older people and funded for three years (2014--7). There is some local level evidence of preventative activities for those with mild frailty and specifically designed health and social care pathways for the frail.[44]. By 2015 the majority of general practices were providing the Proactive Care Programme (7,431 of 7,841 in England) [46]. Evidence of its specific impact for frail older people and other vulnerable groups is difficult to separate from the matrix of local interventions addressing improved integration of services [37] and care management for people with multiple long-term health condition[47]. However the policy has now changed and the Proactive Care Programme has been replaced within the national 2017-18 general practice contract [48]. All general practices are now required to identify those with moderate and severe frailty using a defined index and then focus clinical attention on those "*living with severe frailty, the practice will deliver a clinical review*

providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions" (NHS England 2017)[50] . There are no explicit specific health promotion or prevention components to this contractual requirement.

Discussion and conclusion

This review has analysed contemporary health and social care policy for health promotion for older people with early frailty in England. The review is time limited but that is mitigated by the inclusion of current policies some of which were agreed some time ago. However, even by using a defined time period and type of policy document, our searches may have missed some local examples of difference but we have tried to address this through our iterative processes.

We found that the older population was not always identified separately as a policy priority. From documentary evidence alone it is not possible to determine whether this represented a positive lack of age discrimination or a negative lack of attention to the specific problems of some older people. Other analysts have argued that institutional ageism exists in international health policy [50] . Over time the discourse in these policy documents changed from broad health promotion for older adults, to the specific prevention of ill health and targeted either those most frail or those in mid-life – i.e. an 'upstream' public health solution [6] to earlier in the life course.

There was an absence of policy focus on those on a pathway to frailty. This is group with a reported prevalence of 44% of those over 65 years [7], a population that is predicted to grow in all countries [1]. Publicly funded or supported services seeking to develop health promotion for older people with early frailty may find it difficult to legitimise their plans without a policy 'rationale' to support it amongst the other competing priorities. By merely addressing the adverse events experienced by those with frailty, opportunities are being missed to 'refocus upstream'[6] on health promotion and illness prevention among those on the pathway to frailty.

Declaration of Conflicting Interests

None Declared

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Boxes

- Improved older people's perception of community safety,
- Prevention of social isolation,
- Prevention of falls injuries in those aged 65 years and over.
- Prevention of hip fractures in those aged 65 years and over.
- Prevention of excess winter deaths, with particular attention to those aged over 85.
- Increased proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.
- Improving health related quality of life for people with multiple long-term conditions and carers,

Box 1 Examples of government mandated health improvement outcomes in relation to older people for public health, the NHS and social care [26,27,28]

"*Support independence in older people - what we plan to do:*
• To develop co-ordinated health and social care preventative services and pathways that will enable older people to retain and maintain their independence for longer.
• Develop an Older Persons Strategy to support the coordination and delivery of culturally appropriate services across health, social care, housing and other relevant organisations, and to ensure provision of high quality services
• Increased participation of older people in their neighbourhood to increase social inclusion and general wellbeing." Leicester Health and Well-Being Strategy [41] page 25

"*It is a key priority for the CCG to support older people to stay healthy, manage their condition better and to remain independent for as long as possible. Where they do need to go to hospital, we aim for this stay to be as short as possible and for the patient to experience an improved quality of care. Not only will patients have better health outcomes and quality of care, but by reducing the number of hospital admissions the financial position of the city's health economy will become more sustainable*." Leicester Clinical Commissioning Group Our priorities – older people. [42]

Box 2 Exemplars of priorities for health and care of older people in local strategies [41,42].